DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 2

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/00

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 7/1/00-9/30/00 $ 11,455
b. FFY 10/1/00-9/30/01 $ 45,721

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A.1, Page 5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A.1, Page 5

10. SUBJECT OF AMENDMENT:
Mental Health Preventive Visits

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
not required

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
H. David Bruton, MD

14. TITLE:
Secretary

15. DATE SUBMITTED:
1-20-2000

16. RETURN TO:
Office of the Secretary
Department of Health & Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 28, 2000

18. DATE APPROVED:
November 7, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Crasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Level of Care criteria for ventilator-dependent care is described in Appendix 4 of Attachment 3.1-A.

2.a. Outpatient Hospital Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

(1) Prior approval shall be required for each psychiatric hospital outpatient visit after the first two visits for recipients 21 years and over. No more than twenty-four (24) visits per year will be covered. Approval will be based on medical necessity. This limitation does not apply to EPSDT eligible children.

(2) Prior approval shall be required for each psychiatric hospital outpatient visit after the 26th visit for recipients under age 21.

(3) Routine physical examinations and immunizations are covered under Adult Health Screening and under Early Periodic Screening Diagnosis and Treatment (EPSDT).

(4) "Take home drugs", medical supplies, equipment and appliances are not covered, except for small quantities of medical supplies, legend drugs or insulin needed by the patient until such time as the patient can obtain a continuing supply.